Residential Treatment Services PRTF Information Inventory (9-7-11 draft)

		Comments
Agency Name:	Thompson Child and Family Focus	
Contact Name:	G. Denise Greene, VP continuous QI	
Contact Number:	704-644-4345	
Site/Cottage/Facility Name:	Upper Campus and Lower Campus	
Address:	6800 Saint Peter's Lane, Matthews, NC 28105-8458 Peace Cottage - 6750 SPL, Suite 200 Maroncas Cottage 6750 SPL, Suite 300	Christ Church Cottage: 6722 St. Peters Lane, Matthews, NC 28150; Alphin Cottage: 6750 St. Peters Lane, Suite 400, Matthews, NC 28150; Kenan Cottage: 6736 St. Peters Lane, Matthews, NC 28150; Yorke Cottage: 6750 St. Peters Lane, Matthews, NC 28150; Williamson Cottage: 6700 St. Peters Lane, Matthews, NC 28150; Smith Cottage: 6725 St. Peters Lane, Matthews, NC 28150; The School at Thompson: 6730 St. Peters Lane, Matthews, NC 28150
Mental Health License Number: Peace Cottage-MHL-060-1226 Maroncas Cottage-MHL-060-1227	Christ Church Cottage: MHL-060-830; Alphin Cottage: MHL-060-1172; Kenan Cottage: MHL-060-828; Yorke Cottage: MHL-060-1171; Williamson Cottage: MHL-060-831; Smith Cottage: MHL-060-829; The Schoool at Thompson: (Day Tx) MHL-060-017	NPI #s: Christ Church Cottage: 1972749315; Alphin Cottage: 1114246253; Kenan Cottage: 1780668590; Yorke Cottage: 1396064432; Williamson Cottage: 1326284761; Smith Cottage: 1225275514; The School at Thompson: 1053557496 Peace Cottage 1245536838 Maroncas Cottage 1154627743
Medicaid Provider Number: Peace Cottage 3404581 Maroncas Cottage 3404580	Christ Church Cottage: 3404534; Alphin Cottage: 3404568; Kenan Cottage: 3404532; Yorke Cottage: 3404567; Williamson Cottage: 3404531; Smith Cottage: 3404533; The Schoool at Thompson: 8300456R	Taxonomy #s: Christ Church Cottage: 323P00000X; Alphin Cottage: 323P00000X; Kenan Cottage: 323P00000X; Yorke Cottage: 323P00000X; Williamson Cottage: 323P00000X; Smith Cottage: 323P00000X; The School at Thompson: 251S00000X Peace Cottage 323P00000X Maroncas Cottage 323P00000X
General Overview	***Provide a description of the following:***	
Accreditation Body:	COA	Thompson is a Council On Accreditation (COA) accredited agency that includes PRTF as a part of their child and family continuum of care. There are two distinct PRTF programs referred to as the "Lower Campus" and "Upper Campus".
Gender(s) served:	Lower Campus M/F; Upper Campus M	The "Lower Campus" is designed for male and female children ages 6-12 who have an attachment disorder and a history of trauma.
Number of beds per site:	~~12 Beds at 3 Cottages.~~ Lower- 28 Beds @ 4 Cottages Upper- 24 Beds @ 4 cottages	Each child has their own room and bathroom.

Staff-to-Client Ratio for Service Unit:	daytime 2:1, night 3:1 Lower Campus	Both campuses have daytime child/staff ratios of 2:1 and nighttime 3:1. ~~This cottage~~ is staffed with 2nd and 3rd shift employees during the week because the children go to school every day. All shifts are staffed on the weekend.
Staff Shift Pattern:	Lower Cottage 2nd/3rd shift. Upper Cottage 3 shifts	
Disability served:	Mental Health	
Specialty Population: (Dual Dx, Sexually Reactive/Aggressive, IDD, Bipolar, Schizophrenia, Borderline Personality etc.)	Lower: Atachment/Trauma. Upper: Sexually Reactive	The treatment model is Dyadic Developmental Psychotherapy (DDP). DDP is used to build relationships. All staff are trained in this model and use the model within interactions with the child. Behavior management is achieved with logical/natural consequences and an immediate response. Families are encouraged to visit as much as possible including sharing meals, tucking in at bedtime, etc. Therapists' offices are located in the cottage to facilitate an integrated approach to each child's care. Residential staffs are referred to as "Mentors" as they relate to one or two assigned children in a mentoring relationship. This relationship is essential to children who do not have family involvement as it allows for the relationship repair component of DDP. The "Upper Campus" is designed for male children who have problems with sexually reactive behavior. The children are from age 5 to 15. The upper campus employs a very similar variation of Dyadic Developmental Psychotherapy that focuses on relationship building with attention to good boundaries. Dialectical Behavior Therapy (DBT) is used to build skills for distress tolerance, emotion regulation and coping skills. These skills are taught and used to decrease acting out behaviors including sexual behaviors. Each child has his own room/bathroom and motion sensors are used to alert staff to nighttime movement. Behavior management is achieved with a combination of immediate, natural/logical consequences, rewards and using DBT skills. Because the focus is on relationship building the behavior management is not centered on behavior modification. School is provided on site within the cottage. All shifts are staffed for 24/7 coverage.
Age range:	Lower: 6-12. Upper: 5-15	

IQ Requirement:	Yes, 70+ Campuses	Children admitted to the programs must have an IQ of 70 or above. Both ~~cottages~~ include a variety of recreational activities such as expressive art, drumming, yoga, mindfulness and a lay spiritual life coordinator is available to all children. Chapel is available to any child who wishes to attend. The campus provides outdoor recreation including swimming and playgrounds. Pet therapy is available on a weekly basis. Both ~~cottages~~ use Skype technology for family work in cases where travel is difficult or unrealistic on a regular basis. ~~Behavior graphing is used for each child to determine patterns and response to interventions through the stay.~~
Facility: Locked___ Unlocked___	see below, dependent on facility	
Facility: staff secure?	Lower Cottage Staff Secured	The agency has embraced the relationship building model throughout the entire program. Direct care staff is seen as a primary agent of change for the children. The agency stresses relationship building among staff, with children and families and other community agencies.
Faciliity secured?	Upper Cottage Facility Secured	The Upper Campus is a facility secured, contained environment to increase safety for the children.
Does the facility use restraints?	Yes	Therapeutic Crisis Intervention
Does the facility use seclusion?	no	Seclusion rooms are not used.
Does the facility use timeout?	~~yes~~ no	~~Open door timeout rooms~~ There is a time away room in the school, with no doors that the clients must ask to go to.
Does the facility accept children from out of state?	Rarely	
Agency Treatment Approach/EBP/ Promising Practice/orientation	Lower: Dyadic Developmental Psychotherapy; Upper: Dialectical Behavior Therapy	
What orientation does staff receive?	All staff has a 1 day orientation and further training in the therapeutic model (43 hours + TCI and other specialization training)	
Are Treatment Planning processes integrated (medical and behavioral staff recommendations)?:	Yes, with all staff including an MD and LNP weekly	
How does Direct Care staff relate to Clinical Care Staff?	Integrated with all staff, therapist office is located in each cottage; each resident has 2 mentors who are part of the residential cottage staff	Staff know trauma narrative and try to create a family structure to aid in recovery.

Services available/array for each site:	Comprehensive services including: Individual and family therapy, Intensive In Home, Day Treatment, MD services and staff Psychiatrist	
Education services provided (on-site school, day treatment, outpatient services, etc.):	Lower campus: School on the Thompson site Upper Campus: School within the cottage	School is provided on campus. School program is accepted by the school system. Thompson's school program is accepted by the school system. Many children are behind in school when they come into care. They often are able to catch up at Thompson.
Credits Transferable:	yes	Students are elementary and middle school aged and credits are based on testing. They do not have HS students.
Incident Reporting/Training for On-line Reporting:	Have a policy and procedure for incident reports with methods in place to track and trend. Currently they are using IRIS, the online reporting system.	Thompson's report everything. Staff are trained in orientation on incident reporting. They look at every single incident to discern patterns and this is done within 24 hours of the incident. Tx teams look at pattern of restrictive interventions. An Incident Review Committee presents trends to the Clinical Team. Note that Clients Rights Committee includes external members.
Average Length of Stay:	Lower: 1 yr. Upper 1 1/2 yrs.	
Do you know about the Building Bridges Initiative?	Haven't signed up to be member but are very aware of it and its purpose.	Thompson's has reviewed assessment tools, collaborates with CCNC.
What is the agency's perspective on System of Care?		They have received MeckCares SOC training and believe ithey adhere to SOC philosophy.
Structure and Supervision		
1. Would you characterize the level of structure and supervision provided by your program as low, moderate or high?	Interview: 1. List **types of safety monitoring** used (e.g., staff observation, video cameras). 2. Identify all **areas covered** by safety monitoring. 3. Identify **any gaps** in safety monitoring coverage. 4. Identify **corrections made or proposed** to remediate those gaps?	Thompson characterized the level of structure and supervision as high. The cottages have cameras to help monitor activity in the halls and open areas. T~~he "upper campus~~ All" cottages have motion sensors in the bedrooms to assist with overnight activity monitoring for children who are more at risk of inappropriate behavior. Children do not ever have roommates.
2. What strategies do you employ in order to individualize your service(s)?	Interview: 1. List the **EBPs** and all other therapeutic interventions utilized by the PRTF. 2. List **frequency and description of staff training** pertinent to EBPs and therapeutic interventions.	The treatment model, Dyadic Developmental Psychotherapy and Dialectal Behavior Therapy provide structure to the program as all staff work with the children under the guidelines in the models. Staffs are trained in the treatment model and the developer of DDT visits twice a year for several days to provide ongoing education. The program is individualized to meet each child's needs within the framework of the therapeutic model.

3. Describe the level of supervision and structure provided by your program to assist a child in achieving and maintaining an improved level of functioning so that the child can successfully benefit from treatment and achieve the highest level of independent functioning in order to return to their family or obtain permanent placement?	Interview: 1. Describe how **supervision** of youth is provided. 2. Describe how the level or intensity of **supervision may vary** across youth? 3. Is **supervision described as being based on individual risk and/or therapeutic need**? Yes or No. 4. Describe how **discharge plans** prepare the youth for a successful **step-down**. 5. Is the discharge plan described as including **specific goals** that need to be accomplished prior to discharge? Yes or No. 6. Describe the **involvement of the CFT** in the discharge policy.	From Day One, Team begins planning for discharge. Spervision is based on individual risk and or therapeutic need with specific goals that need to tbe accomplished prior to discharge.
4. What is the safety monitoring policy/procedure for determining the assignment of roommates?	Interview: 1. What are the characteristics that would promote or prevent **pairing of clients** as roommates? 2. What happens when characteristics of concern come to light and how is change made owing to these characteristics? 3. What are **safety monitoring practices** applicable during the day? at night?	Each child has their own room and bathroom.
Adjustment and Functioning		
1. Describe strategies for assisting the client in improving their interpersonal relationships at school, work and in other community activities.	Interview: 1. How does your program promote improvements in **interpersonal skills**? 2. How does your program **measure improvements** in interpersonal skills? 3. What is the frequency of **physician contact** with each youth? 4. What are the **standard physician contacts** with each youth? 5. How does the program assure access to appropriate **medical and dental care**? 6. How are daily **living skills** promoted? 7. How are they **measured**?	The treatment model at Thompson, Dyadic Developmental Psychotherapy, requires relationship building with the community. The program is well integrated in the community and builds relationships with many other agencies such as DSS, dentists, and community organizations. Volunteer agencies often provide festivals, activities and events for the children. Successful integration and appropriate responses in the community are a part of treatment and individualized for each child.
2. Describe treatment interventions used to ensure that a child acquires the skills necessary to compensate or remediate skill deficits.	Interview: 1. List the **EBPs** and all other therapeutic interventions utilized by the PRTF. 2. List frequency and description of staff training pertinent to EBPs and therapeutic interventions. 3. List the **characteristics (targeted areas of functioning, age, gender, diagnoses) of the consumers** for whom the each intervention is employed.	Program tries to utilize and reiterate skills such that child takes ownership in a way that leads to long term change.

3. How are clients encouraged to interface with community supports for the development of personal resources?	Interview: 1. What **opportunities are there for children to interact** in the socially/recreationally in the community/outside the facility? 2 . Are there different opportunities available to individual consumers based on assessed needs? What **strategies/interventions are there to promote a child's successful engagement** with community activities/resources? 3. How does the agency prepare the child for **community re-entry**?	Lower campus does safe outings in the community. This is true to a lesser extent for Upper Campus. Volunteers come on campus to do cookouts, festivals. Home visits with safety plans also contribute to child's interactions in home and community. As child gets closer to discharge there are more home visits. Staff uses impulse control strategies to aid with external interactions. Small staff ratios makes these interactions more feasible.
4. Describe how your program involves the family in treatments, keeps them informed of their child's progress, and prepares them for step down as part of the discharge process.	Interview: 1. Describe **the involvement of the family/guardian/supports** in Treatment Planning? 2. Describe the involvement of the family/guardian/supports in **implementing treatment**? 3. Describe the involvement of the family/guardian/supports in **determining progress** of the plan? 4. Describe **the involvement of the Child and Family Team (CFT)** in Treatment Planning?	Thompson tries to involve family/CFT from initial entry into program into tx planning. Intent is for family to participate in therapy in person or otherwise whenever possible.
Behavior Management		
1. Discuss your agency's basic approach to behavior management.	Interview: 1. Is there a **privilege system**? 2. Are there **different levels** in the privilege system? 3. **Describe** your privilege system. Is it in writing? 4. How is it **communicated** to youth in the faciity? 5. How does a child earn the right to move from one level to another? 6. Are privileges based on avoiding **negative behavior or on reinforcing positive behavior**?	When needed Therapeutic Crisis Intervention (TCI) is used to deescalate out of control behaviors. Therapeutic holds are used as a last resort to prevent harm to self or others. Otherwise, behavior management techniques specific to each child based on their triggers and coping responses are incorporated in the child's PCP and crisis plan. The therapeutic models used in the cottages provide daily modeling and reinforcement of coping skills to prevent a crisis.
2. Describe how your program handles severe, out-of-control behavior, including verbal and physical aggression, sexually reactive, offending behaviors, self-injurious, property damage, and clients who have problems in the community.	Interview: 1. Do you **accept children who are/ have/cause**: a) severe out of control behaviors (e.g., psychosis, firesetting, animal cruelty and other antisocial behaviors)___ b) physically aggressive___ c) sexually reactive___ d) sexually aggressive___ e) offending behaviors___ f) self injurious___ g) property damage___. 2. What **behavior management techniques** do you apply for these behaviors (as applicable)?	yes, Thompson's will accept really extreme children. They are at the same time concerned about revictimization and so are conscious of that in their acceptances. ~~They will turn down children who cannot do work cognitively, if they are a danger to self or others or if there is a medical condition~~. Thompson will consider, ~~on a~~ case by case, children that struggle with cognitive ability, children considered to be a danger to themselves or others, & children with medical conditions.

3. What precautions are taken to prevent harm to a child or others?	Interview: 1. What is the facility's **philosophy** regarding seclusion/restraint? 2. When/how are **staff taught to use** that philosophy? 3. What trainings have been provided to avoid using **seclusion/restraints**? 4. What seclusion/restraint trainings do staff receive? 5. What happens **after a restraint**?	Thompson's can video spotcheck children in hallways and common areas ~~rooms~~. All staff have TCI training. There are no seclusion rooms. There is a doorless ~~timeout~~ time away in school room This model has decreased incidents for the children. All incident reports are reviewed with 24 hours including Level I incidents.
Clinical Oversight		All children have a scheduled Day
1. Discuss how therapeutic interventions are integrated into the daily schedule of the residential program.	Interview: 1. What is the **daily schedule**? 2. Does it include free time? 3. How are **meals** handled (e.g., preparation, clean-up)? 4. What structure is provided during **transition periods**? 5. How are **therapeutic interventions integrated** into daily routines? 6. What **on site activities** are available during free time? 7. Describe how staff help youth to find their interests.	~~Each child has an individualized schedule~~. There is a daily recreation time, weekly expressive arts. There is 1:1 time. School runs through the summer. Each cottage has an assigned therapist with an office located in the cottage. Upper campus has DBT groups. Upper Campus has meal in cottage and fix meals in the kitchen. Lights out at 8-8:30 pm.. The therapist spends time with the children and staff. They are able to guide interventions and work with the children in real time. All staff starts work with a structured orientation. Clinical staff attends program specific training on and off campus. The program has a weekly treatment team meeting with medical, clinical and residential staff.
2. Describe how a professional provides clinical oversight to the program. How many hours/week?	Interview: 1. Describe the **clinical oversight of staff** in the facility? 2. **How often** does supervision occur/**How many hours per week** is such oversight provided? 3. **Who provides clinical oversight?** 4. Is supervision **formal or informal** in nature? Describe. 5. What are **credentials** of staff providing such oversight? 6. If a QP, who supervises said QP?	Therapists are in the cottages. Staff model attachments. Staff are directly supported by program supervisor. Staff have supervision with two licensed therapists. Agency stresses relationships.
3. How does the program assure access to the appropriate care for clients in crisis situation?	Interview: 1. Does each individual have an **individualized criis plan**? 2. How are crisis plans **individualized?** Please give an example. 3. What **crisis resources** exist internally and externally?	Each child has an individual crisis plan which is part of the child's PCP. Therapists know the child's potential crisis points. The Internal Review Committee reviews the crisis plans and de-escalation techniques associated with those plans. Therapists are on call.
Referral Process		

1. What is/was the initial referral process prior to PRTF entry?	Interview: 1. Describe the involvement of the **CFT in making referrals for admission**? 2. Describe the **involvement of the family/guardian/supports in ref**erral decision making? 3. How are children referred to the the facility?	Children will see the same psychiatrist throughout their stay. Parents can self-refer. Hospitals often refer patients. Parents and families often make the first contact. Use SKYPE sessions with no HIPPA concerns as long as there is consent. Thompson's continues to build relationship with community partners. Many of the children they work with are Medicaid recipients. Children can move up or down their continuum of service or may be referred to other agencies when necessary.
2. How is a client referred to another level of services?	Interview: 1. How is it determined that a client is ready to or should **move to another level of care**? 2. What circumstances would cause an **unplanned discharge** and who would be involved?	If the child is local, an internal referral can be made to local IIH, outpatient, school or day tx programs. If not local, staff would work with CFT. There are very few unplanned discharges. Sometimes parents will pull a child from the program.
3. Describe your coordination of post discharge and follow up care.	Interview: 1. Describe **post discharge** and follow up care?	Thompson's tries to do follow up surveys (these are rarely returned). Parents will sometimes call to check in. Can sometimes trackvia Facebook.
Self Evaluation		
1. How would you characterize the type of child your program is most successful in treating?	Interview: 1. How would you characterize the **type of child your program** is most successful in treating?	The most successful children are those with very committed families.
2. What type of behaviors poses the greatest problem for program staff to manage?	Interview: 1. What type of **behaviors poses the greatest problem** for program staff to manage?	Those who struggle are those with an emerging mental illness or who are mentally ill. Organic disorders are not fixable. 50% of children have no significant external guardian to rely on or look out for them.